Chapter 2 - Nutrition Services

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ALASKA WIC NUTRITION SERVICE STANDARDS

Nutrition Service Standards

Nutrition services in WIC begin with an initial screening and assessment of the participant's nutritional status and determination of all applicable nutritional risk conditions. Based on this assessment, a food package is prescribed and appropriate nutrition education is provided. Certified participants are informed as to the specific nutritional risk condition(s) qualifying them for the WIC Program.

Nutrition services are provided based on an understanding of the varied food-related beliefs, customs and behaviors of the diverse ethnic and cultural populations served by the Alaska WIC program. Nutrition information is provided to these diverse populations in a sensitive, respectful and helpful manner.

Local Agency Staffing Requirements

Local Agency Coordinator Requirement

Local Agency Coordinator

A person must be designated by each local agency to be responsible for coordination of the WIC Program. Qualifications for the local agency coordinator position include possession of credentials as:

- A Registered Dietitian (RD) or eligible for registration with the American Dietetic Association (ADA), with one year public health experience. A Masters Degree with an emphasis in public health nutrition, food and nutrition, nutrition education, human nutrition, nutritional science or equivalent, may be substituted for the work experience.

- A nutritionist with a Masters Degree with emphasis in the areas listed above, with one year of public health or nutrition experience. RD eligible preferred.

- An Alaska WIC certified Competent Professional Authority (CPA) who has successfully passed the Alaska WIC CPA certification examination. This option is intended primarily for use as a qualified alternative for rural areas or areas where it is difficult to recruit and retain RDs and Nutritionists.

Competent Professional Authority

Competent Professional Authority (CPA)

A local agency must employ only competent professional authorities to determine nutritional risk through a medical and/or nutritional assessment. A competent professional authority (CPA) means an individual authorized to determine nutritional risk and prescribe supplemental foods. The following persons are the only persons the state agency may authorize to serve as a competent professional authority: physicians, nutritionists (bachelor's or master's degree in nutritional sciences, community nutrition, clinical nutrition,

dietetics, public health nutrition or home economics with emphasis in nutrition), dietitians, registered nurses, physician's assistants (certified by the National Committee on Certification of Physician's Assistants or certified by the State medical certifying authority), or an Alaska WIC certified CPA who has passed the Alaska WIC Competent Professional Authority certification examination.

Local Agency Nutrition Service Standards

Nutrition services are provided by the Alaska WIC Program in accordance with federal USDA regulations, policies and guidelines. The standards for local agencies are:

Local Agency Nutrition Service Standards

- USDA nutrition risk criteria are used by all local agencies to determine eligibility.
- A uniform statewide dietary assessment tool is used by all local agencies to determine dietary risk for all applicants.
- Uniform anthropometric and biochemical assessments based on current practice are used by all local agencies.
- Food packages are tailored in accordance with current authoritative medical and health information.
- Standard policies for all nutrition education contacts are used statewide.
- Standard evaluation procedures are used for evaluating nutrition education.
- Appropriate, high quality, accurate nutrition education materials are used by all local agencies.
- Each local agency develops an annual WIC nutrition education plan consistent with the State's nutrition education component of program operations as specified in the State's goals and objectives and desired outcomes.
- It is preferred that a Registered Dietitian or Nutritionist with a Master's degree in a nutrition field perform the following:

    - Oversee direct nutrition services to participants, and provide technical assistance and consultation regarding nutrition services to local agency staff and other health professionals.
    - Provide nutrition education and counseling for all high risk participants, and prepare High Risk Nutrition Care Plans for these participants.
    - Provide nutrition in-service training to local agency staff.
    - Develop each local agency's annual WIC nutrition services plan.

    When a local agency demonstrates in good faith that it does not have access to either a Registered Dietitian or Nutritionist with a Master's degree in a nutrition field then an Alaska WIC certified CPA may perform the above duties. However, Local Agencies must show good faith that

they are pursuing ways to obtain a qualified professional to provide services to high risk clients and/or at minimum develop high risk care plans for CPAs to implement.

NUTRITION RISK ASSESSMENTS

Risk Assessments

To be certified as eligible for the program, applicants who meet the categorical, residential, identity and income eligibility requirements must also be determined to be at nutritional risk.

The Alaska WIC Nutritional Risk Criteria manual should be used to assign nutritional risks during certification and recertification. Copies of the manual are available from the state agency office. The manual is based on the standard USDA nutritional risk criteria. The manual covers the following:

Risk Code Manual USDA and Alaska Risk Code Criteria

- Which conditions identified during certification are allowable risks for WIC certification.
- Numbers used in the AKWIC computer system for these conditions.
- Cut-off values for risks.
- USDA definitions for each risk.
- Detailed descriptions for each risk.
- Categories (pregnant, breastfeeding or postpartum woman, infant or child, to whom a risk can be applied.
- Which risks are "high- risk" requiring referral for high risk nutrition education/consultation
- Which risks are automatically calculated by the AKWIC computer system.

A copy of the standard certification form listing all risks and codes is included at the end of this chapter.

Definition of Nutritional Risk

Definition of Nutritional Risk

A nutritional risk is any measurable indicator or circumstance that is associated with the increased likelihood of an adverse health outcome. The cutoff point for a nutritional risk is the point above or below which an individual is judged to be at risk. This may be a numerical value such as a hemoglobin value, or a dichotomous variable (i.e., yes, the applicant has the condition; or no, he or she does not). A nutritional risk is thus determined by a risk indicator plus its cutoff point, such as a hemoglobin level of <11 gms./dl in a pregnant woman in the first trimester of pregnancy.
Nutritional risk is evaluated to select participants who are at risk of developing specific health problems if they do not receive WIC benefits. Nutritional risk indicators predict nutrition benefit and health risk reduction from participating in the WIC Program. A complete nutritional assessment to determine nutritional risk includes anthropometric measurements,

hematological tests, a medical history and dietary assessment. The nutritional risk must be determined by a registered dietitian, Nutritionist or Alaska WIC Certified CPA. This determination may be based on referral data submitted by a CPA not on the staff of the local agency.

Data Collection

Nutritional Risk Data Collection Requirements

Local agencies are authorized to conduct anthropometric and hematological measurements to determine nutritional risk, or to use medical referral data from other health care providers for anthropometric and hematological measurements. If medical referral data from another provider is used, it may be provided on a WIC referral form, or it can be written on the WIC application form in the "Office Use Only" section of the application form by the provider, if they have copies of the forms. If they do not have WIC forms, the WIC local agency may accept the data in writing or by telephone from the other provider. WIC staff must then fill in the information in the "Office Use Only" section of the application form.

For each certification and recertification, at a minimum, height or length and weight must be measured, and a hematological test for anemia such as a hemoglobin or hematocrit must be performed. Hematological tests are not required for infants under six months of age.

Height or length and weight measurements and blood tests must be obtained for all participants, including those who are determined to be at nutritional risk based solely on the established nutritional risk status of another person, such as the breastfed infant of a WIC participant. Weight and height or length must be measured not more than 60 days prior to certification or recertification for program participation. Blood test data must not be more than 90 days. Data for pregnant women must be collected during their pregnancy, and data for postpartum and breastfeeding women must be collected after the termination of their pregnancy.

Anthropometric Assessments

Anthropometric Assessments

Each infant and child must have their height and weight plotted on a growth grid. Women must have their prepregnancy weight for height evaluated and pregnancy weight gain plotted on the appropriate weight gain grid. Repeated measurements should be plotted on the same growth grid to assess growth trends.
Use of the growth grids in the WIC computer system is recommended. If the computer grid is used, it is not required that a paper copy of the grid be placed in the participant's paper file.

Correct Techniques for Taking Anthropometric Measurements

Anthropometric Measurement Techniques

Scales should be calibrated at least twice a year using standard weights. Clinics with high volume should calibrate scales three to four times a year.

Weighing Infants

- Set the scale to zero and make sure it balances. The scale should balance when set to zero and nothing is on it. If it does not, it should be adjusted.
- Ask parent to take off child's clothes, including diaper. If the clinic staff prefer to weigh in infant with a diaper on, the weight of the diaper should be subtracted from the infant's weight.
- Place the child on the scale and balance by moving the weights. Move the larger weight before moving the smaller weight.
- Record weight to nearest quarter of an ounce. Reset the scale to zero.
- Confirm measurement value (weigh a second time).

Weighing Infants

Measuring Length of Children Under the Age of Two

This procedure requires two persons:

- Remove shoes.
- One person positions the head against the headboard with child looking straight up.
- The other person then straightens the infant's legs with the toes pointing upwards and moves the heel board until it is flat against the bottom of the feet. Make sure it is against the heel. Holding the infant's legs together just above the knees and gently pushing both down against the board can help to fully extend the legs.
- Record length indicated by the foot board to nearest 1/8 inch.
- Confirm measurement value (measure a second time).

Measuring Length of Children Under Two

Weighing Children and Adults

- Set the scale to zero and make sure it balances. If it does not balance, the scale should be adjusted.
- Have the client remove shoes and heavy clothing. The participant should stand still over the center of the scale with body weight distributed evenly between both feet.
- Balance by moving the weight. Move the larger weight before moving the smaller weight.
- Record weight to nearest quarter of a pound, reset scale to zero.
- Confirm measurement value (weigh a second time).

Weighing Children and Adults

Measuring Height of Children and Adults

- Have participant remove shoes.
- Have participant stand with heels, buttocks, shoulders and head against measuring board or wall with weight distributed evenly on both feet. Arms should hang freely by the sides with the palms facing the thighs. Line of vision should be straight ahead.

Measuring Height of Children and Adults

- Move triangle down until it touches top of head with sufficient pressure to compress the hair. (Be sure children do not hunch down).
- Ask client take a deep breath and maintain a fully erect posture.
- Record measurements to the nearest 1/8 inch.
- Confirm measurement value (measure a second time).

Measuring Head Circumference

Measuring Head Circumference

- Use a flexible, nonstretchable measuring tape.
- Position the child standing or in a sitting position on the caregiver's lap.
- Place the lower edge of the measuring tape just above the eyebrows, above the ears and around the occipital prominence at the back of the head.
- Pull the tape snugly to compress the hair. The objective is to measure the maximal head circumference.
- Repeat the measurement twice or until two measurements agree to 0.1 cm (1/16 in.)
- Record the numerical value and plot it on the appropriate growth chart.
- If the measurement appears abnormal when plotted, check the accuracy of the plotting and recheck the measurement.

Hematological Tests

Iron Deficiency Anemia

The most common nutrition-related anemia is iron deficiency anemia, which may be caused by:

- A diet low in iron
- Insufficient assimilation of iron from the diet
- Increased requirements due to growth or pregnancy
- Blood loss

The rate of iron deficiency anemia among children in Alaska, particularly among Native children, has been found to be about double the national average. Iron deficiency anemia in children has been linked with growth retardation, and deficits in development and cognitive function.

Each applicant must have hemoglobin or hematocrit test to screen for anemia. These tests do not directly measure iron levels or distinguish among types of anemia. Other causes of anemia are possible, but iron deficiency anemia is by far the most common cause of anemia in children and women of childbearing age.
This test can be performed in the WIC clinic, or blood test data from another agency or health care provider may be accepted. Such data may be accepted by telephone if written data are not available at the time of certification or recertification.

Blood Test Dates

Local agencies may accept blood test data that are no older than 90 days prior to WIC certification.

In rural Alaska, where health care services may be intermittent, the blood test requirement can be a barrier to access to WIC services.

Deferring Blood Tests for 90 Days

Local agencies may defer the collection of blood test data for up to 90 days after the date of certification, but the applicant must have at least one other qualifying nutritional risk factor at the time of certification. If the collection of blood test data is deferred, local agencies must ensure that the data is obtained within the 90 day period. This can be done by sending reminders and/or placing these participants on monthly warrant pickup.

The State agency may disallow the option to defer the collection of blood work data for those local agencies that exhibit poor performance in obtaining the required data. (Poor performance would include, for example, a management evaluation indicating that blood test data for participants are <u>not</u> collected within 90 days after certification.)

Blood Tests by Other Providers

Local agencies are encouraged to work with pediatricians, family practice physicians and other health care providers concerning collection of blood test data. Not only will this eliminate the need to subject participants to unnecessary finger pricks to obtain hemoglobin measurements but it will also mean that local agency staff will not have to duplicate this effort. To facilitate the exchange of information between WIC and other providers, the WIC Referral Request form should be used by providers to record hemoglobin, and anthropometric data.

Blood test data are necessary and important in fully assessing nutritional risk, providing nutrition education, tailoring WIC food packages, and targeting WIC benefits to those at greatest risk. Skillful management of referral blood test data for WIC eligibility determination can result in effective coordination of services, minimize potentially repetitive and invasive blood test procedures, and reduce cost and participant inconvenience.

Local agencies should use good professional judgment as to whether to use data from earlier tests without a recheck of abnormal blood test results, for more critical situations, on a case-by-case basis, in order to provide adequate follow-up services.

Safety Precautions When Conducting Finger/Heel Stick

Universal Precautions

All local agency workers should use universal precautions and prevent injuries caused by needles when doing collection of blood for hemoglobin or hematocrit tests.

Gloves should be worn:

- Use gloves for performing finger and/or heel sticks.
- Use gloves for performing hemoglobin test or when the health care worker has cuts, scratches, or other breaks in his/her skin.
- Use gloves in situations where the health care worker judges that hand contamination with feces, urine, or blood may occur, e.g., when performing hemoglobin test on an uncooperative patient.
- Use gloves when persons are receiving training in performing finger and/or heel sticks.
- Use gloves for handling items or surfaces soiled with blood or body fluids to which universal precautions apply.

Gloves should be changed after contact with each patient. Hands and other skin surfaces should be washed immediately or as soon as patient safety permits if contaminated with blood or body fluids requiring universal precautions. Hands should be washed immediately after gloves are removed. If hand washing is not convenient, use of antibacterial hand gel may be substituted until hand washing is done. Gloves should reduce the incidence of blood contamination of hands during phlebotomy, but they cannot prevent penetrating injuries caused by needles or other sharp instruments. Gloves should always be available to health care workers.

All health care workers should take precautions to prevent injuries caused by lancets. To prevent injuries, lancets should not be recapped by hand, purposely bent or broken by hand, or otherwise manipulated by hand. After they are used, lancets, should be placed in puncture-resistant containers. The puncture-resistant containers should be located as close as practical to the use area. Containers should be disposed properly once full.

Universal precautions do not apply to human breast milk.

For more information on Universal Precautions:

www.cdc.gov/ncidad/hip/Blood/UNIVERSA

Blood Test Requirements for WIC Certification

Category	Anemia Screening Schedule
Women:	
Pregnant	**During their current pregnancy**
Postpartum	After the termination of their pregnancy
Breastfeeding	After the termination of their pregnancy[1]
Infants	Once between the ages of 9-12 months[2]
Children	Once between the ages of 12-24 months[3] (one blood test at or before 12 months cannot fulfill the requirements for the infant and the 12-24 month child screening) Annually between the ages of 24-60 months[4]

[1]For breastfeeding women 6-12 months postpartum, no additional blood test is necessary if a blood test was obtained after the termination of pregnancy.
[2]A blood test taken between 6-9 months of age can be used to meet this screening requirement.
[3]A blood test is recommended 6 months after the infant test, at around 15 to 18 months of age.
[4]Children ages 24-60 months with a positive anemia screening result require a follow-up blood test at 6-month intervals.

Exceptions to Blood Test Requirements

Exceptions to Blood Test Requirement

Exceptions to the blood test requirement rule are:

- Infants under six months of age.
- Children whose hemoglobin or hematocrit tested normal within their last certification period. However, the blood test must be performed on such children at least once every 12 months.
- Applicants whose religious beliefs do not allow them to have blood drawn. A statement noting the applicant's refusal to have the blood test must be included in the applicant's file.
- Applicants with a medical condition such as hemophilia or a serious skin disease for whom the blood test could be harmful to the applicant. A health care provider's documentation of the medical condition must be included in the applicant's file.

If a medical condition precludes hematological testing, local agencies should attempt to obtain information on possible anemia from the applicant's health care provider. These attempts should be documented in the applicant's file. If attempts to obtain this information are unsuccessful, the applicant may be certified based on other nutritional risk criteria. If the noted condition is considered treatable, such as a serious skin disease, a new statement from the health care provider is required for each subsequent certification. If the condition is considered "lifelong", such as hemophilia, a new statement for each certification is not necessary.

Refusal of Blood Test by Applicant

Refusal of Blood Test

If an applicant or applicant's parent or guardian refuses to have a blood test done, and the refusal is not based on medical or religious grounds, the applicant cannot be certified for WIC, even if the certification would have been based on a risk factor other than anemia. This does not apply to infants under six months of age, or children who are not due for a blood test because their hemoglobin or hematocrit tested normal within their last certification. However, such children will be required to have a blood test when they are recertified, unless it is precluded based on medical or religious grounds.

Children's Blood Test Requirements

Blood Test Requirements for Children

The blood test for anemia is not required for children who were determined to be within the normal range at their last WIC certification, but a blood test must be performed on such children at least once every 12 months. Anthropometric and hematological test data obtained from tests conducted not more than 90 days prior to certification for WIC Program participation may be used to determine program eligibility.

A discrepancy is created by allowing the use of prior data that may be up to 90 days old at the time of certification, along with the option to waive the blood test for a child whose test results were within the normal range at the previous WIC certification. Using these two options together conflicts with the requirement that a blood test be performed on all children participating in the WIC Program at least once every 12 months.

Consider, for example, the case of a child who was initially certified in January 1997 using blood test data that were normal from October 1996 (i.e., data obtained within the mandatory 90-day timeframe). When this same child was certified in July 1997 for another 6-month period, no blood test was required because the blood values were within the normal limit for the January 1997 certification. At the child's next certification in January 1998, a blood test is required. In this example, a total of 15 months elapsed between the blood tests, yet the local agency was not out of compliance with the WIC regulations for using the October 1996 data or for exempting the child from a blood test in July 1997.

In these situations, a local agency is not out of compliance with program regulations if, by choosing to utilize the options to use data not more than 90 days old and waiving the blood test requirement for children who were determined to be within the normal range at their last certification, 15 months elapse between blood tests.

Dietary Assessment

Dietary Assessment

Local agencies are required to assess and document dietary intake for all applicants, for the purpose of determining nutritional risk due to inadequate diet and developing nutrition care plans. Dietary intake for women and children is assessed using the Alaska WIC Program Dietary Assessment form included in this chapter, and questions regarding dietary habits on the application form. Dietary intake for infants is assessed using the Infant WIC Application form.

Analysis of dietary intake is based on professionally recognized guidelines, including current RDA standards, guidelines of the American Academy of Pediatrics, and the U.S. Dietary Guidelines for Americans.

Nutrition Related Medical Conditions

Nutrition Related Medical Conditions

Each applicant must be screened for medical conditions and diseases impacted by nutritional status, based on an assessment of current and historical health provided on the WIC application form. Risk conditions that are not visible or documented will not be used as eligible risk factors unless confirmed verbally or in writing by a health care provider. This means, for example, that a condition such as diabetes or a respiratory disease would have to be documented in writing or by telephone.

Presumptive Eligibility for Pregnant Women Certified for Medicaid

Presumptive Eligibility for Pregnant Women

A pregnant woman who is certified for Medicaid is presumptively eligible to participate in WIC. She may be certified immediately without waiting until a nutritional risk determination is made. A nutritional risk assessment must be completed not later than 60 days after the woman is certified for participation. However, it is important to perform the dietary risk assessment before or as soon as possible after the presumptively eligible pregnant woman begins receiving WIC benefits. The longer it takes to complete the assessment, the more likely it is that a woman who would have been eligible for program benefits due to inadequate diet will not be eligible because dietary inadequacies were eliminated through the woman's participation in the program.

Computer System Risk Code Summary

Computer Risk Codes

The following numerical codes are used for recording risks in the WIC computer system. Some risks are automatically calculated by the WIC computer system based on data such as hematocrit or hemoglobin test results, or heights and weights. Others, such as nutrition-related risk conditions or inadequate/inappropriate nutrient intake, must be manually entered into the computer system by WIC staff.

The risk codes which are **underlined and in bold print** are automatically calculated and assigned to a participant at the time of certification by the WIC computer system. All other risk codes must be individually assigned by the CPA at the time of certification , and must be manually entered into the participant's computer record.

- **Low weight/height - 11**
- **High weight/height - 12**
- **Short stature - 13**
- **Inappropriate growth/ weight gain pattern - 14**
- **Low birth weight/premature birth – 16**
- **Other anthropometric risk – 17**
- **Low Hematocrit/Hemoglobin – 21**
- Elevated blood lead levels – 22
- Pregnancy induced conditions – 31
- Delivery of low birth-weight/premature infant – 32
- Prior stillbirth, fetal or neonatal death - 33
- General obstetrical risk - 34
- Nutrition-related risk conditions - 35
- Substance abuse - 36
- Other health risks - 37
- Dental Problems-38
- Developmental/Sensory/Motor Delay/Feeding Problem-39
- Fetal Alcohol Syndrome-40
- Inadequate/inappropriate nutrient intake - 41
- Other dietary risk – 49
- Presumptive eligibility - 90
- Regression/transfer – 91
- Breastfeeding mother at Risk Infant- 92
- Breastfeeding complications - 93
- Infant WIC Eligible Mom - 94
- **Homeless or migrant – 95**
- Other nutritional risks – 96
- Infant of Mental Retardation orSubstance Abuse Mom – 97
- Breastfeeding infant of at Risk Mom– 98
- Recipient of Abuse/Neglect-99

Priority Groups

Priority Group Assignments with Nutritional Risks

Each category of participant (pregnant women, breastfeeding women, infants, children, and postpartum women) is assigned to a priority group by the AKWIC computer system after the risk(s) have been entered into the system for the participant.

The ranking of the priority system is based on the severity of nutritional and/or medical risks. Priority I is the group of highest risk; Priority VII is the group of lowest risk. The nutritional and medical risks, with the computer system risk code numbers, are listed below for each participation category and priority group. Each category of participant does not necessarily contain all priority groups.

Pregnant Women

Priority I

11 - Low weight/height
12 - High weight/height
14 - Inappropriate growth/ weight gain pattern
21 Low Hematocrit/Hemoglobin
22 - Elevated blood lead levels
31 - Pregnancy induced conditions
32 - Delivery of low-birthweight/premature infant
33 - Prior stillbirth, fetal or neonatal death
34 - General obstetrical risk
35 - Nutrition-related risk conditions
36 - Substance abuse
37 - Other health risks
38- Dental Problems
39- Developmetnal/Sensory/Motor Delays

Priority IV

41 - Inadequate/inappropriate nutrient intake
49 - Other dietary risk
90 - Presumptive eligibility (up to 60 days after certification only)
91 - Regression/transfer
95 - Homeless or migrant
96 - Other nutritional risks
99- Recipient of Abuse

Breastfeeding Women

Priority I

11 - Low Weight/Height
12 - High weight for height
14 - Inappropriate growth/weight gain pattern
21 - Low Hematocrit/Hemoglobin
22 - Elevated blood lead levels

31 - Pregnancy induced conditions
32 - Delivery of low-birthweight/premature infant
33 - Prior stillbirth, fetal or neonatal death
34 - General obstetrical risk
35 - Nutrition-related risk conditions
36 - Substance abuse
37 - Other health risks
38- Dental Problems
39- Developmetnal/Sensory/Motor Delays
93 - Breastfeeding complications

Priority IV

41 - Inadequate/inappropriate nutrient intake
49 - Other dietary risk
91 - Regression/transfer
95 - Homeless or migrant
96 - Other nutritional risks
99- Recipient of Abuse

Variable Priority

92 - Breastfeeding mother of infant at nutritional risk (must be the same priority as the at-risk infant)

In assigning priority to this risk factor, the breastfeeding mother is assigned the same priority used in certifying her infant. This can be Priority I, II, or IV. For example, if a breastfeeding mother is certified as Priority I, her infant will also be certified as Priority I, no matter what actual risk the infant may have.

Infants

Priority I

11 - Low weight/height
13 - Short Stature
14 – Inappropriate growth/ weight gain pattern
16 – Low birth weight/premature birth
17 – Other anthropometric risk
21 – Low Hematocrit/Hemoglobin
22 – Elevated blood lead levels
35 – Nutrition-related risk conditions
37 - Other health risks
38- Dental Problems
39- Developmetnal/Sensory/Motor Delays
40- Fetal Alcohol Syndrome

93 – Breastfeeding complications
97 - Infant born of woman with mental retardation or alcohol or drug abuse during most recent pregnancy

Priority II

94 - Infant up to 6 months old of a WIC-eligible mother or mother at risk during pregnancy (WIC infant)

Priority IV

41 - Inadequate/inappropriate nutrient intake
49 – Other dietary risk
91 – Regression/transfer
95 - Homeless or migrant
96 – Other nutritional risks
99- Recipient of Abuse

Variable Priority

98 - Breastfeeding infant of woman at nutritional risk (must be the same priority as the at-risk mother)

In assigning priority to this risk factor, the breastfeeding infant is assigned the same priority used in certifying her mother. This can be Priority I, II, or IV. For example, if a breastfeeding infant is certified as Priority I, her mother will also be certified as Priority I, no matter what actual risk the mother may have.

Children

Priority III

11 - Low weight/height
12 - High weight/height (first three certifications)
13 - Short stature (first three certifications)
14 – Inappropriate growth/ weight gain pattern
16 – Low birth weight/premature birth (<24 months of age only)
17 – Other anthropometric risk (<24 months of age only)
21 – Low Hematocrit/Hemoglobin
22 – Elevated blood lead levels
35 – Nutrition-related risk conditions
37 - Other health risks
38- Dental Problems
39- Developmetnal/Sensory/Motor Delays
40- Fetal Alcohol Syndrome

Priority V

41 - Inadequate/inappropriate nutrient intake
49 – Other dietary risk
95 - Homelessness or migrant
96 – Other nutritional risks
99- Recipient of Abuse

Priority VII

91 – Regression/transfer

Postpartum Women

Priority III

11 - Low weight/height
12 - High weight/height
14 – Inappropriate growth/weight gain pattern
21 – Low Hematocrit/Hemoglobin
22 – Elevated blood lead levels
31 - Pregnancy induced conditions
32 – Delivery of low-birthweight/premature infant
33 – Prior stillbirth, fetal or neonatal death
34 - General obstetrical risk
35 – Nutrition-related risk conditions
36 - Substance abuse
37 - Other health risks
38- Dental Problems
39- Developmetnal/Sensory/Motor Delays

Priority VI

41 - Inadequate/inappropriate nutrient intake
49 – Other dietary risk
91 – Regression/transfer
95 - Homelessness or migrant
96 – Other nutritional risks
99- Recipient of Abuse

High Risk Participants

High Risk Participants

Certification as High Risk

Participants must be certified as high risk if the assessment indicates that they are at special risk of adverse health outcome. Participants certified as high risk must be referred for high risk nutrition education/consultation.
A high risk nutritional care plan must be done by a Registered Dietitian, or a person holding a BS, MS or PhD in the field of nutrition (Nutrition Service Standard 1. E.1.a and 1.c) before the next nutrition contact. The care plan may be developed by telephone contact with the participant for participants who receive services by mail. Local public health nurses or health aides may be helpful in establishing contacts. Each high risk participant must receive at least one high risk consultation per certification period. High risk care plans can be implemented by a CPA.

What Is High Risk?

Pregnant Women

High Risk Pregnant Women

Pregnant women are determined high risk if their assessment indicates that they are at special risk of adverse health outcome. Pregnancy problems stem from two types of conditions: complications induced by the pregnancy itself and preexisting chronic disease in the mother.

Pregnancy induced conditions include low hematocrit/hemoglobin , hyperemesis gravidarum, pregnancy-induced hypertension (PIH) and gestational diabetes. In some cases, the normal physiologic stress of the pregnancy imposes demands on a relatively poor maternal nutritional status or on reserves that are inadequate to meet the new needs.

Preexisting disease in the mother, such as insulin-dependent diabetes mellitus (IDDM), phenylketonuria (PKU), or chronic hypertension, brings risk to the pregnancy. Other preexisting maternal conditions include drug addiction, acquired immunodeficiency syndrome (AIDS), bulimia, anorexia nervosa.

Other high risk factors include teenage pregnancy, late maternal age and women of high parity.

Infants

High Risk Infants

The determination of high-risk infants is related to birth weight, gestational age, and weight for gestational age. The highest risk is among those weighting less than 1000 gm at birth and those born at less than 30 weeks gestation. Other risk factors include difficult resuscitation at delivery, multiple or other high-risk pregnancy, infection, serious illness, congenital anomalies, hematologic problems, or surgery.

High Risk Computer Codes

High Risk Criteria and Risk Codes

The chart on the following page shows high risk factors by participant category and AKWIC computer codes. These conditions require referral for high risk nutrition education/consultation. The consultation must take place as soon as possible but not longer than two months after certification. Referrals to other health care providers, i.e., physicians, PHNs, dentists, or health educators may be necessary as well.

High Risk Codes: Alaska WIC (Revised November 2002)

AK	USDA	I	C	PG	BF	NBF	**Risk Factor**
11	103	☆	☆				Underweight (< 5th% P at initial cert or < 10th %P for 2 consecutive cert)
14	131			☆			Low Maternal Weight Gain
	134	☆	☆				Failure To Thrive
16	141	☆					Low Birthweight (Birth weight < 5 lbs)
	142	☆					Prematurity (< 37 gestation)
17	151	☆					Small for gestational age
	152	☆					Low Head Circumference
21	201	☆	☆	☆	☆	☆	Low Hematocrit/Low Hemoglobin (Hgb <9 gms/dl or Hct, 30%)
22	211	☆	☆	☆	☆	☆	Elevated Blood Lead Levels
31	302			☆			Gestational Diabetes
34	331			☆	☆		Pregnancy at a Young Age Conception (< 15 years, PG/BF)
	335			☆	☆		Multifetal Gestation
	336			☆			Fetal Growth Restriction (FGR)
35	341	☆	☆	☆	☆	☆	Nutrient Deficiency Diseases
	342	☆	☆	☆	☆	☆	Gastrointestinal Disorders
	343	☆	☆	☆	☆	☆	Diabetes Mellitus
	344	☆	☆	☆	☆	☆	Thyroid Disorders
	345	☆	☆	☆	☆	☆	Hypertension (Includes Chronic and Preg Induced)
	346	☆	☆	☆	☆	☆	Renal Disease, (excluding UTI)
	347	☆	☆	☆	☆	☆	Cancer
	348	☆	☆	☆	☆	☆	Central Nervous System Disorders
	349	☆	☆	☆	☆	☆	Genetic and Congenital Disorders
	350	☆					Pyloric Stenosis
	351	☆	☆	☆	☆	☆	Inborn Errors of Metabolism
	352	☆	☆	☆	☆	☆	Infectious Diseases
	353	☆	☆	☆	☆	☆	Food Allergies
	354	☆	☆	☆	☆	☆	Celiac Disease
	356	☆	☆	☆	☆	☆	Hypoglycemia
	357	☆	☆	☆	☆	☆	Drug-Nutrient Interactions
	358			☆	☆	☆	Eating Disorders
	359	☆	☆	☆	☆	☆	Recent Major Surgery, Trauma, Burns
	360	☆	☆	☆	☆	☆	Other Medical Conditions
	362	☆	☆	☆	☆	☆	Developmental/ Sensory/ Motor Disabilititers:Feeding Problems
36	372			☆	☆	☆	Alcohol and Illegal Drug Use
37	382	☆	☆				Fetal Alcohol Syndrome (FAS)
93	602				☆		BF Complications or Potential Comp's (Women)
93	603	☆					BF Complications or Potential Comp's (Infants)

Nutrition Care Plans

Nutrition Care Plans for Non-High Risk Participants

The Nutrition Care Plans are nutrition education tools. They are provided to WIC CPAs to use as a general guide to provide nutrition education to WIC participants. They cover all possible identifiable USDA WIC nutrition risks, however, they are not intended to completely cover all possible participant scenarios. The Nutrition Care Plans were adapted and revised from the Arizona WIC Program by the Alaska Association of WIC Coordinators (AKAWICC) Competent Professional Authority (CPA) Committee members. Other resources used to develop them included the AKAWICC Nutrition Education Committee materials, the USDA Risk Factor Manual, AKAWICC committee members' experiences, and the AKWIC Food list.

Before using the Nutrition Care Plans, Paraprofessional CPA's are trained to identify nutritional risk conditions and criteria that are allowable risk factors for WIC eligibility; to understand the number system used to identify the AKWIC factors; to identify risk factors on the WIC certification form; to identify nutritional risk factors for WIC participants according to the USDA Nutrition Risk Manual; to understand how to use the Nutrition Care Plan Manual to provide nutrition counseling to WIC Participants. Finally, CPAs are trained to identify which risk factors are "high risk" and should be referred to a dietitian.

CPA's who are Physicians, Nutritionists, Registered Dietitians, Registered Nurses, or Physician's Assistants may utilize the Nutrition Care Plans as a guide in developing or adapting individual care plans for non-high risk and high-risk participants.

CPAs using the Nutrition Care Plans need to assess the participant's area of concern as well as their readiness to learn. It is suggested that the Nutrition Care Plans are used in conjunction with appropriate basic counseling strategies.

The Nutrition Care Plans are available as a printed manual or from the Alaska WIC web site http://health.hss.state.ak.us/ocs/nutri/Admin/education/nutritioncareplans/default.htm

Nutrition Care Plans for High Risk Participants

An individual care plan must be developed if a participant is determined to be high risk; when a CPA determines it is needed; or when a participant requests an individual care plan. The high risk care plan is developed by either a Registered Dietitian, or a person holding a BS, MS or PhD in the field of nutrition, (Nutrition Service Standard 1. E.1.a and 1.c). The care plan is kept in the participant's paper or computer file. Using the Nutrition Care

Plan form included at the end of this Chapter is optional as long as an assessment and the guardian's desired outcomes are included in the plan developed by the client and provider. Charting objective or medical information in the computer note is not required if the information is already captured in the computer. The plan can be implemented by other staff, under the supervision of the CPA. High risk pregnant and breastfeeding women and guardians of high risk infants and children will receive at least one in person, individual high risk counseling session per certification period. Counseling may be done by telephone in rural areas.

If it is determined that a high risk pregnant woman, infant or child could benefit from additional individual care beyond the high risk contact, the participant may be referred to Medicaid. If the participant is referred for specialty nutrition care, the local agency will remain responsible for documenting that participants receive at least two nutrition education contacts within a certification period.

A proxy may not attend a high risk consultation in place of a high risk participant, or in place of the parent or guardian of a high risk infant or child.

NUTRITION EDUCATION

Nutrition Education

Local WIC agencies provide individual counseling at the time of certification which is specific to the participant's nutritional risk. At the time of certification, local agencies assess nutritional status, identify nutritional risk and provide nutrition counseling. Subsequent nutrition contacts promote the development of sound eating habits and optimal nutrition status. Nutrition education means individual, group session or the provision of materials that are designed to improve health status and achieve positive change in dietary and physical activity habits and that emphasize the relationship between nutrition, physical activity and health, all in keeping with the personal and cultural preferences of the individual.

Nutrition Education Plans

Local Agency Nutrition Education Plans

Local agencies are required to develop written nutrition education plans that include needs assessments, measurable goals and objectives, action plans and an evaluation component. These plans must be submitted to the state agency each year as part of the annual local agency funding application. They are reviewed by the state WIC Nutritionist and other appropriate staff.

The plan should address the following:

- Relationship of nutrition services to area needs assessment.
- Risk assessments.
- Individual nutrition consultations.
- Nutrition services for participants in remote areas.

- Relationship of nutrition services to individual participant needs.
- Nutrition education activities, including:
  - ⇒ sample lesson plan
  - ⇒ tailoring to individual participant needs
- Breastfeeding promotion and support.
  - ⇒ provision of information to pregnant participants
  - ⇒ follow-up after delivery of infant
  - ⇒ support for breastfeeding women
  - ⇒ continued encouragement
  - ⇒ referrals and links with breastfeeding support groups

Nutrition Education Plan Requirements

At a minimum, the plan must include:

- A needs assessment of the local agency area's demographic, geographic, cultural, and other factors which may affect the provision of nutrition education. For example, a high percentage of Hispanics may indicate the need for classes conducted in Spanish, or a high incidence of baby bottle tooth decay may indicate nutrition education on dental health as a high priority;
- A list of local agency goals and measurable objectives for nutrition education processes and procedures;
- A description of how nutrition education will be provided to all adult participants, parents/caretakers of infant and child participants and wherever possible, child participants; and
- A description of a system for integrating, where possible, the services of community resources such as the Expanded Food and Nutrition Education Program or Head Start with the nutrition education services provided to the participants.

Nutrition education efforts are tailored to meet the needs of special populations through requiring local agencies who serve special populations to address their needs in local agency nutrition education plans, distribution of resource materials related to special populations, and coordinating at the state and local levels with agencies who serve special populations.

Goals and Objectives

Nutrition Education Plan Goals and Objectives

Objectives should be outcome oriented statements that are measurable and quantifiable. They are used to measure progress toward goals.

Objectives should:

- describe realistic, achievable and measurable outcomes;
- define the period of time required for implementing or completing the objective;
- illustrate a solution to, or an improvement of, a specific situation or condition; and

- define the criteria that will be used to measure progress.

For example: "The prevalence of breastfeeding at the postpartum visit will increase from 50% to 70% of participants as indicated on PNSS reports."

Evaluation

Each year local agencies applying for renewed funding of an existing program must include nutrition education evaluation results for the previous fiscal year. New applicants who have operated similar programs should include evaluation results from the most recent period during which they operated a similar program.

Nutrition education Plan Evaluation

The annual nutrition education plan must include an evaluation plan. In general, the evaluation plan should describe how the local agency will tell whether or not it accomplished the year's objectives. Ultimately the evaluation criteria should be measures of outcome. However, the plan should also indicate how progress toward those outcomes will be assessed or monitored. Timeframes must be included, although, as indicated previously, applicants do not need to limit objectives to only those that can be achieved in a one-year time-frame.

To evaluate progress local agencies are to consider:

- What information will be collected.
- When it will be collected.
- How it will be collected and documented.
- How the local agency will know if an objective is met.
- How results compare to baseline information.
- How new or revised services or systems will be evaluated for effectiveness, efficiency, or other characteristics.

Evaluation Strategies

A variety of evaluation strategies can be used:

- Data from chart review.
- Computer data from the new WIC computer system.
- Participant surveys.
- Manual data collection forms developed for use at specific times.
- PNSS and PedNSS reports.

The state agency monitors progress toward meeting nutrition education goals and objectives bi-annual on-site visits.

Annual Participant Survey

Annual Survey of Participant Views on Nutrition Education and Breastfeeding Promotion

Local agencies are required to assess participant views on nutrition education and breastfeeding promotion at least once a year. Questionnaires can be developed by local agencies. The results are used in the development of the

local agency nutrition education plan. Results must be reported to the state agency as part of the annual nutrition education plan.

Nutrition Education Materials

Nutrition Education Materials

Nutrition education materials are made available to local agencies by the state agency. The Nutrition Education form lists all the materials available for local agencies to order. Pamphlets, flyers, booklets and posters are mailed from the Juneau office. The Anchorage office maintains a loan library of nutrition education visual aids, and a reference library of books which are available for loan. The lists of materials available for loan are periodically mailed to local agencies, and additional copies are available upon request.

The state agency uses standard criteria to ensure that nutrition education materials are appropriate in content, reading level and graphic design. All nutrition education materials except newsletters developed by local agencies must be sent to the state agency for review before printing and distribution.

Nutrition Education Newsletters

Newsletters

Newsletters developed by local agencies should supplement information provided in nutrition education materials in an attractive, easy-to-read format. Recipes in newsletters should meet the Dietary Guidelines for Americans to promote the theme that nutritious foods are also tasty.

Nutrition Education Contacts

Nutrition Education Contact Requirements

General nutrition education can be provided by nutritionists, registered dietitians, home economists, nurses, dietetic technicians, or WIC certified CPA staff. Counseling for high risk participants is preferred to be provided by a registered dietitian or nutritionist. A WIC certified CPA in Alaska may provide high risk counseling if a local agency does not have access to either a Registered Dietitian or Nutritionist.

Initial nutrition education must take place during the certification appointment. The legal guardian of a child or infant, or the pregnant, postpartum, or breastfeeding woman, applying for WIC benefits must be present for certification or recertification. A proxy may not attend in place of the applicant or legal guardian.

Subsequent nutrition education is provided through individual or group sessions which are appropriate to the individual participant’s nutritional needs. This includes interactive displays and other creative methods of providing nutrition education.

Nutrition Education Contact Methods

Nutrition education contacts are provided in either of the following ways:

- Participants who pick up their warrants on-site receive nutrition education offered individually or in group sessions.
- Participants who receive warrants in the mail or who receive mailed food boxes receive mailed nutrition education materials (i.e., brochures, videos, newsletters, etc.) sent by the local agency to the participant.

Contact Frequenc

Frequency of Contacts

During each six-month certification period, at least two nutrition contacts must be made available to all adult participants and the parents or caretakers of infant and child participants and wherever possible, child participants themselves.

Nutrition contacts are made available at a quarterly rate, but not necessarily taking place within each quarter, to parents or caretakers of infant participants certified for a period in excess of six months. For example, an infant is certified at age three months. She can be certified up to her first birthday, provided her length, weight, hemoglobin and diet is assessed 6 months after her initial certification. The parent(s) should receive three nutrition education contacts during her nine-month certification period, but the contacts do not need to be at exactly three-month intervals.

Proxy Nutrition Education

Nutrition Education by Proxy

A proxy is a spouse, domestic partner, boyfriend, parent of an adolescent prenatal participant, grandparent, or other person with a close personal relationship with the participant which, in the judgment of the CPA, enables them to serve as an effective representative of the participant. The proxy may attend subsequent nutrition education classes in the place of the participant, but not the initial certification or recertification appointment. Documentation of proxy attendance is required, in the participant's file or a master file.

A proxy may pick up warrants for a participant at subsequent appointments, but not at the initial certification or recertification appointment.

Nutrition Education Contact Documentation

Documentation of Contacts

Nutrition education provided at certification and recertification must be documented in the participant's computer file. Any subsequent nutrition education during a certification provided to a participant in a group setting may be documented in the AKWIC computer system or in a master file. If a participant misses a nutrition education appointment, the local agency must document this fact in the participant's paper or computer file, or a master paper file.

NUTRITION EDUCATION STANDARDS

Infants

Infant Intake Assessment Standards

Food	Age of Infant				
	0-4 mo	4-6 mo Pureed	6-8 mo Str/Pureed	8-10 mo Mashed Table	10-12 mo Cut Table
Breastmilk	On Demand Approx 8-12+ feedings	On Demand Approx 6-8+ feedings	On Demand Approx 4-8 feedings	On Demand Approx 4-6 feedings	On Demand Approx 4-6 feedings
Formula w Fe+	16-32 oz	24-32 oz	24-32 oz	24-32 oz	24-32 oz
Infant Cereal	-	1-4 T	1-6 T	4-8 T	4-8 T
Vegetables	-	-	1-4 T	4-6 T	4-6 T
Fruit	-	-	1-4 T	4-6- T	4-6 T
Fruit Juice (cup)	-	-	2 oz	2-3 oz	3-4 oz
Meat, Fish, Poultry, Cooked Dried Beans or Egg Yolk	-	-	1-2 T	2-4 T	4 T
Teething Biscuit/Infant Crackers	-	-	1	1	1
Starch, Potato, Rice	-	-	-	2 T	2 T

Infant Nutrition Education Standards

Nutrition education local agencies provide to guardians of infant participants should promote the development of sound eating habits and optimal nutrition for the infant. Topics to be addressed include, but are not limited to:

Infant 0-5 Months

- Importance of iron fortified formula if formula fed
- Vitamin D, fluoride and iron supplementation for the breastfed infant
- Fluoride supplementation for the formula fed infant
- Importance of immunizations and well child care

- Introduction of solids
- Normal growth and development
- Inappropriate feeding practices (i.e., propping a bottle, early introduction of solids, etc.)

Infants 6-11 months

- Introduction of additional solid foods
- Introduction of juice from a cup and weaning to cup
- Importance of iron fortified formula until 1 year of age
- Baby bottle tooth decay
- Normal growth and development
- Anemia and iron rich foods
- Prevention of choking
- Promoting the development of self-feeding skills
- Important of immunizations and well child care

Recommended Supplementation

Fluoride

Starting at about 6 months a breastfed infant should receive 0.25 mg of fluoride per day, if he or she is only fed breastmilk or breastmilk with solid foods. The American Academy of Pediatrics (AAP) recommends that, because breastfed infants drink little or no water, they should receive fluoride supplements whether or not they live in communities with optimally fluoridated water. The AAP Committee on Nutrition recommends initiating fluoride supplementation shortly after birth in breastfed infants (0.25 mg fluoride per day) and according to the fluoride content of the drinking water in formula-fed infants. Satisfactory reduction in the prevalence of dental caries can be accomplished by initiating fluoride supplementation as late as six months of age.

Fluoride given on an empty stomach is 100% bioavailable, but if administered with milk or a calcium-rich meal will be incompletely absorbed. For infants, the supplement should be given between feedings.

Iron

Infants should receive an iron supplement starting at 4 – 6 months of age if they are nor receiving iron-fortified formula or iron-fortified infant cereal. The amount of supplementary iron depends on the size and maturity of the infant.

Vitamin D

Exclusively or partially breastfed infants should receive 400 IU of vitamin D starting at age six weeks. All WIC infants and children on Medicaid or Denali KidCare over the age of six weeks who are partially or exclusively breastfed are eligible for WIC vitamin D supplements, funded by Medicaid. Exclusively breastfed infant means that they receive only breastmilk or breastmilk plus solid foods. WIC nutritionists, registered dietitians, and Alaska certified CPAs are allowed to issue the vitamin drops. A notation should be made in the infant or child's paper or computer record that the vitamins were issued.

Mead Johnson's liquid Tri-Vi-Sol Vitamin A, C and D drops in 50 ml bottles should be distributed. A daily dose of one ml, contains 1500 IU vitamin A, 35 mg vitamin C, and 400 IU vitamin D. A one ml dropper is included in each bottle. These vitamins are also available as "off the shelf" products.

Vitamin drops can be ordered from the state WIC office. WIC local agencies within Native Health Corporations should explore obtaining vitamin supplements from the corporation, as WIC funding to buy the vitamins is very limited.

Parent Education on Vitamin D

Parents need to know:

- Breastmilk remains the best source of nutrition for an infant and child
- Vitamin D is important for healthy bone growth and development
- Vitamin D supplements are recommended in Alaska for certain infants
- How to give the vitamin drops
- How to get more vitamins
- To stop the vitamins if the infant goes on formula (continue vitamins if infant with dark skin is partially formula-fed)
- To stop the vitamins when the child begins to drink vitamin D fortified milk on a daily basis
- To store the vitamins safely out of the reach of children

A parent education brochure is available from the state WIC office.

Inventory & Storage of Vitamin D

All WIC infants and children are income-eligible for Denali KidCare. If they are not already enrolled, they should be referred to this excellent program.

An inventory should be kept of the supply of vitamins on hand, and kept at the clinic. The vitamin drops should be stored in a secure place that is dry and cool (59F to 89F is good.) The vitamins should be protected from direct sunlight and from freezing. Returned bottles of vitamins cannot be reissued. Dispose of them immediately.

Solid Foods for Infants

Solid Foods

- Solid foods should be added one at a time when the infant is able to sit with support and has good neuromuscular control of head and neck. The infant should be able to indicate desire for food by opening the mouth and leaning forward, and to indicate disinterest by leaning back and turning away (about 4-5 months). Iron fortified rice cereal is recommended as the first solid food, then vegetables, fruit and meat. Exclusively breastfed infants should be fed meat earlier to ensure an adequate intake of protein, iron and zinc. Solid foods should be introduced one at a time, with an interval of several days between new foods to check for signs of intolerance.

- Finger foods and foods of different textures should be offered when developmentally appropriate.

- Solid foods are recommended not only to meet nutritional needs but to encourage and support developmental changes. Consuming less solid foods than recommended will not necessarily result in an inadequate diet. The baby is the best judge of how much to eat.

Juice

- Excess fruit juice should be avoided. No more than 4 oz from a cup is recommended on a daily basis. The importance of feeding juice from a cup instead of bottle should be stressed.

Honey

- Honey, including that used in cooking or baking or found in prepared foods (e.g. yogurt with honey, peanut butter with honey) should not be offered to infants. When consumed by an infant, honey, which is sometimes contaminated with *clostridium botulinum* spores may cause infant botulism, a type of serious food borne illness. Corn syrup and other syrups on the market are not sources of *clostridium botulinum* spores, and are not associated with infant botulism.

Water

- Healthy infants fed adequate amounts of breastmilk or infant formula in the first 6 months of life generally do not require additional plain water added to their diet.

Caffeine

- Beverages containing caffeine and bromine are not recommended for infants. Coffee, tea and some carbonated beverages such as colas and hot chocolate contain these substances.

Sweetened Drinks

- Sodas, fruit drinks, punches, sweetened gelatin water, sweetened ice tea and other beverages with added sugar are not recommended for infants because of their high sugar content.

Herbal Teas

- Certain herbal teas contain powerful substances similar to drugs and are not appropriate for infant consumption.

- Baby foods prepared for an infant at home can be equally nutritious and more economical than commercially prepared baby food.

Baby Foods

- When commercial baby foods are used, single ingredient foods are preferred over combination foods or dinners. Combination foods or dinners are more expensive ounce for ounce and usually have less nutritional value by weight than single ingredient foods.

- Infants should not be fed baby food desserts such as puddings, custards and cobblers which contain added sugar.

Foods to Avoid

- Due to the risk of choking, it is best to avoid feeding infants these foods:
  - ⇒ Raw vegetables (including green peas, string beans, celery, carrots, etc.)
  - ⇒ Cooked or raw whole corn kernels
  - ⇒ Hard pieces of raw fruit
  - ⇒ Whole pieces of canned fruit
  - ⇒ Nuts, seeds, or popcorn
  - ⇒ Whole grapes, berries, or cherries with pits
  - ⇒ Hot dogs or stringy, tough meat
  - ⇒ Peanut butter
  - ⇒ Hard cheese
  - ⇒ Uncooked dried fruit (including raisins)
  - ⇒ Hard candy

Nutrition Education Standards for Children

Children

Nutrition education provided by local agencies to parents and guardians of child participants and child participants themselves should promote the development of sound eating habits and optional nutritional status for the child. Nutrition education will also emphasize the relationship between nutrition, physical activity and health.

Topics to be addressed include but not limited to:

Children 12-24 Months

- Weaning, if not already completed
- Fluoride supplementation
- Baby bottle tooth decay
- Anemia and iron rich foods
- Dental nutrition
- Normal growth and development

- Nutritious snacks
- Meeting nutritional needs of the toddler (food guide pyramid and appropriate portion sizes)
- Normal toddler eating habits
- Importance of whole milk until 2 year of age

Children 2 years - 5 years

- Nutritious snacks
- Dental nutrition
- Normal growth and development
- Anemia and iron rich food
- Meeting the nutritional needs of the preschooler (food guide pyramid and appropriate portion sizes)
- Promotion of physical activity

Pregnant Women

Nutrition Education Standards for Pregnant Women

Nutrition education provided to the pregnant participant should promote the development of sound eating habits and optimal nutritional status. Topics to be addressed include but are not limited to:

- Relationship of diet to pregnancy outcome
- Diet during pregnancy (Food Guide Pyramid)
- Vitamin and mineral supplements
- Weight gain during pregnancy
- Dealing with discomforts of pregnancy (i.e., morning sickness, constipation, etc.)
- Substance abuse (tobacco, alcohol, drugs)
- Fetal development
- Breastfeeding promotion and guidance

When a pregnant woman is certified, local agency staff should emphasize that:

- Breastfeeding women may receive WIC benefits for up to one year postpartum while non-breastfeeding women are eligible for only six months postpartum.
- WIC offers a greater variety and quantity of food to breastfeeding participants than to non-breastfeeding postpartum participants.
- Breastfeeding women are at a higher level in the WIC priority system than non-breastfeeding postpartum women, and are more likely to be served than postpartum women when local agencies do not have the resources to serve all individuals who apply for the WIC Program.

These benefits, especially the greater amount of food, can be presented as additional incentives to breastfeed. At the very least, postpartum participants

should fully understand the full range of program benefits available to them regardless of their choice of infant feeding method.

Postpartum Women (Breastfeeding and Non-Breastfeeding)
Nutrition education provided to the postpartum participant should promote the development of sound eating habits and optimal nutrition status, and emphasize the relationship between nutrition, physical activity and health and support breastfeeding if appropriate. Topics to be addressed are include but are not limited to:

Nutrition Education Standards for Breastfeeding Women

Breastfeeding

- Breastfeeding resources, support, techniques, and problem solving
- Diet during breastfeeding (food guide pyramid)
- Substances to avoid when breastfeeding (tobacco, alcohol, drugs)
- Folic acid and birth defects
- Exercise and weight management

Nutrition Education Standards for Non-Breastfeeding Women

Non-Breastfeeding

- Food guide pyramid
- Exercise and weight management
- Folic acid and birth defects
- Substance abuse and impact on health

Breastfeeding Promotion and Support
"Breastfeeding" for WIC certification is defined as "the provision of mother's milk to her infant on the average of at least once a day".

Breastfeeding Promotion Standards

Standards
The state agency coordinates with local agencies to implement breastfeeding promotion activities that encourage the development of breastfeeding coalitions, task forces and forums; develop breastfeeding promotion materials; provide breastfeeding aids to WIC participants, as appropriate; provide training for state and local agency staff; and, to the extent possible under present funding, employ certified lactation consultants and peer counselors.

Local WIC agencies should create a positive clinic environment which endorses breastfeeding as the preferred method of infant feeding by:

- Designating a staff person to coordinate breastfeeding promotion and support activities.
- Incorporating task-appropriate breastfeeding promotion and support training into orientation programs for new staff involved in direct contact with WIC participants.
- Ensuring women have access to breastfeeding education and support activities during the prenatal and postpartum periods.

Breastfeeding Aids Standards

Policy for Providing Breastfeeding Aids to WIC Participants

The intent of breastfeeding promotion in the Alaska WIC Program is to promote optimal infant health by increasing the incidence and prevalence of breastfeeding. This is accomplished through providing WIC participants with breastfeeding information, encouragement and support. Providing breastfeeding aids is one way to support a subset of breastfeeding mothers and babies in special circumstances and is thus, an allowable expenditure for promoting and supporting breastfeeding.

Allowed Breastfeeding Aids include:

- Electric breastfeeding pumps
- Pedal breast pumps
- Manual breast pumps
- Single pumping kits (for use with the electric breast pump)
- Double pumping kits (for use with the electric breast pump)
- Breast shells
- Infant feeding tube devices

Breastfeeding Aids Policies

Breastfeeding aids purchased with WIC funds must be provided free of charge to pregnant or breastfeeding women participating in the Alaska WIC Program.

Breastfeeding aids must not be provided to all pregnant or breastfeeding women solely as an inducement to consider or to continue breastfeeding. Some research suggests that providing pumps and other breastfeeding aids to all breastfeeding women, regardless of need, may have the unintended effect of discouraging breastfeeding. The practice may give breastfeeding women the impression that special supplies and/or equipment are needed to successfully breastfeed, and thus reinforce a lack of confidence.

Breast pumps, single and double pumping kits, breast shells, infant feeding tube devices and disposable infant feeding tube devices which come into contact with mother's milk are provided to a lactating participant for her use only and must not be used by anyone else. In order to avoid the possibility of contamination, these devices must not be received back by the WIC agency and redistributed for use by another individual.

Electric breast pumps must be loaned, not given, to lactating participants.

Reasons for Providing Breastpumps

Reasons for providing breast pumps to a participant include:

- Mothers who are having difficulty in establishing or maintaining an adequate milk supply due to maternal and infant illness.
- Temporary mother/infant separation (such as hospitalization or a return to work or school).
- Mothers who have temporary breastfeeding problems, such as engorgement.

- For any other reason that the nutrition counselor feels a pump will enhance the breastfeeding experience or will help the mother continue successful breastfeeding (prior approval by the local agency WIC Coordinator is required).

Breast Shells

Breast Shells - Breast shells may be provided to women with inverted or sore nipples. They may be given during either the prenatal or postpartum period.
Infant Feeding Tube Devices - Thorough education and follow-up are necessary for any participant who receives an Infant Feeding Device. The infant's physician must be notified that the device has been prescribed.

Infant Feeding Tube Devices

Reasons for the use of an Infant Feeding Tube Device include:

- infant with sucking problems
- infants who have latch-on-problems
- mothers with low milk supply
- infants who are reluctant to nurse
- premature infants
- infants with low weight gain
- infants with cleft palate
- adopted infants
- other problems (prior approval by the local agency WIC Coordinator is required).

Education on Breastfeeding Aids

Education

Before a participant is loaned an electric breast pump or given a manual breast pump, single or double breast pump kit, breast shell or infant feeding tube device, instruction on the appropriate assembly, proper use and, if applicable, cleaning of the breastfeeding aid must be provided by trained staff.

Breastpump Forms

Required Breastpump Forms

Prior to issuing a breastpump to a participant, the Breastpump Loan and Release Agreement form included at the end of this chapter must be completed and signed by the participant and the WIC representative. The original must be put in the participant's paper file and a copy must be given to the participant.
In addition, the Breastpump Checklist form included at the end of this chapter must be completed, signed by the WIC representative, and placed in the participant's paper file.

Record Keeping and Security for Breastfeeding Aids

Record Keeping/Security

Documentation of the prescription of any breastfeeding aid must be included in the WIC participant's file. Documentation must include the type of breastfeeding aid provided, the reason the breastfeeding aid was provided, a brief summary of the content of the instruction provided, and the name of the qualified staff person who provided the instruction.

Local agencies must keep a log to record issuance of electric and pedal breast pumps. The log for electric breast pumps must include contact information, with name, address and telephone number of the borrower. Electric breast pumps are WIC equipment and must be tagged and inventoried according to the state WIC equipment policy in Chapter 8.

Careful attention must be given to the security of all breastfeeding aids; for example; keeping them in a locked cabinet or room at the clinic.

Follow up on Breastfeeding Aids

Follow-up Contact

At least one follow-up contact by a trained person is recommended within 24-48 hours for WIC participants who receive manual breastfeeding pumps, pedal pumps, electric breastpumps, single or double breast pump kit, or infant feeding tube devices. This contact can be made by telephone and is to assure that the breastfeeding aid is operating correctly and that the participant is using it properly. Documentation of this contact should be made in the WIC participant's file.

Breastfeeding Aids for Off Site Participants

Off-Site Participants

Off-site participants should be notified that breastfeeding aids are available to assist them in successfully breastfeeding. When issuing a breast pump to an off-site participant, contact with the participant should be made by telephone (if possible). Appropriate instructional materials must accompany the breastfeeding aid. Local agency staff should work with any available on-site health care providers or other health care personnel to provide necessary education and follow-up.

Breastfeeding Peer Counseling to WIC Participants

Using Loving Support

The Alaska WIC Program promotes and supports breastfeeding in collaboration with a strong statewide support network strengthening existing *Using Loving Support* projects and enhancing the continuity of WIC's current breastfeeding management and counseling efforts. In *Using Loving Support* to implement Best Practices in Peer Counseling, support plans are identified and developed for WIC communities statewide. For more information on Breastfeeding Peer Counseling, go to: *Administration* on http://health.hss.state.ak.us/ocs/nutri.

Alaska WIC Breastfeeding Promotion Program
Breastpump Loan and Release Agreement

The _____ WIC Program is extremely pleased with your decision to provide your infant with the *Best Nutrition Choice!* To support your efforts we have available manual, pedal and electric breastpumps for your use. The pedal and electric breastpumps are available on a loan basis. Breastfeeding WIC participants agree to abide by the Loan and Release Form Agreement, in order to borrow the pedal and electric breastpumps.

WIC Participant Information

Date: _____ SS#:_____ WIC Clinic:_____

Name _____ Infant's Birthdate: _____
Last First Middle

Mailing Address_____ City _____ Zip _____

Home Phone#_____ Message #_____

Residence Address_____ City _____ Zip _____

Breastfeeding Pump Issued	**Pump Serial Number**
☐ Medela Lactina Select Electric Breastpump	_____
☐ Medela Pedal Breastpump	_____
☐ Advanced Breastpump Accessory Kit	_____
☐ Spring Express Manual Breastpump System	_____

Reason for Issuance _____

Check as appropriate:

- ❑ I have received and understand instructions for operating this breastpump.
- ❑ I have received and understand instructions for cleaning this breastpump.
- ❑ I have received instructions for returning this breastpump.
- ❑ I agree to follow the instructions for operating and cleaning this breastpump.
- ❑ I understand that the _____WIC Program, or its representatives, cannot be held responsible for any personal damage caused by the use of this breastpump. I release the _____WIC Program from any liability regarding my use of this breastpump.
- ❑ I understand this breastpump is a loan from the _____WIC Program, and that it is loaned to me on a priority basis. I may be required to return it for use by a higher priority WIC participant.
- ❑ I understand that I must return the breastpump undamaged or replace it at a Cost of $595.00 for the electric and $26.40 for the pedal breastpumps.

Our supplies are limited so please return the breastpump, when you no longer need it.

WIC Participant Signature _____ Date_____

WIC Representative Signature _____ Date _____

Breastpump Returned Date _____

Checklist for Instructing Breastfeeding WIC Participants on Using Breast Pumps

WIC Participant Name:_____

Instructions: Complete the tasks listed below in person or over the phone. Initial on the space provided.

1. _____ Breast Pump Loan and Release Agreement form reviewed and signed. Original in the file, and a copy given to client.

2. _____ Demonstrate pump kit assembly, show or send video with the pump for the client to view before using it. Disassemble the pump and have client put it together.

3. _____ Demonstrate how to hook kit up to electric pump.

4. _____ Demonstrate how to adjust suction on pump.

5. _____ Help client, as appropriate, use pump or express milk from both breasts. Be available, in person or by phone, to help client.

6. _____ Demonstrate how to take apart the pump, and which parts need to be washed.

7. _____ Review cleaning instructions. (Sterilization instructions must be reviewed for mothers of very small, pre-term infants and infants with an immune deficiency).

8. _____ Demonstrate how to close the carrying case.

9. _____ Review breastfeeding/pumping routine with client. (Provide handout *A Mother's Guide to Milk Expression and Breast Pumps,* La Leche League International. Order from Juneau.)

10. _____ Review breast milk collection and storage with the client. (Provide handout *Breastmilk Collection and Storage, Guidelines For Normal Newborns,* Medela.

11. _____ Give client the name and phone number of the clinic to call if she needs help.

12. _____ Notify client an RD/RN/IBCLC or Breastfeeding Peer Counselor will call within 24 hours and at least weekly to follow up.

_____ _____

Staff Signature Date

High Risk Nutrition Care Plan: *Infants/Children*

Date: _____ Client: _____

Parent/Guardian: _____ DOB: _____ Age: _____

Physician: _____ Referral Agency: _____

PHN: _____ Case Manager: _____

Reason for Referral:_____

Subjective

Appetite: ❑ Good ❑ Fair ❑ Poor

GI complaints: ❑ Yes ❑ No If yes, check all that apply: ❑ Diarrhea ❑ Nausea ❑ Constipation ❑ Vomiting ❑ Other _____

Weight history: _____

Feeding concerns: ❑ Yes ❑ No Describe: _____

Parent/Guardian concerns: _____

Health and Social Service program participation: ❑ WIC ❑ Food Stamps ❑ Medicaid ❑ ILP ❑ HCP-CSHCN ❑ ATAP ❑ Healthy Families ❑ Other:

Objective

Gestational age _____ Birthweight _____ Length/Height _____ %tile

Length/Height ____ %tile Head Circumference ____ %tile Weight/Height _____ %tile

Laboratory Values: Hemoglobin: _____ Other: _____

Medications: ❑ Yes ❑ No If yes, list: _____

Drug/Nutrient Interaction: _____

Vitamin/Mineral Supplements: ❑ Yes ❑ No Type: _____

Assessment

Growth:_____

Feeding Skills: _____

Feeding Behavior: _____

Plan (developed by client and provider)

1. Guardian Desired Outcomes: _____
2. Education Provided: _____
3. Action Plan: _____
4. Referrals: _____
5. Follow-up Needed? ❑ Yes ❑ No Reason for Follow-up: _____
   Date of Follow-up: _____

Signature: _____ Date: _____ Phone Number: _____

High Risk Nutrition Care Plan: *Women*

Date: _____ Client: _____

Physician: _____ DOB: _____ Age: _____

PHN: _____ Referral Agency: _____

Case Manager: _____

Reason for Referral: _____

Subjective

Appetite: ❑ Good ❑ Fair ❑ Poor

GI Complaints: ❑ Yes ❑ No If yes, check all that apply: ❑ Diarrhea ❑ Nausea ❑ Constipation ❑ Vomiting ❑ Other _____

Concerns regarding weight and weight gain? ❑ Yes ❑ No Describe: _____

_____

Client Concerns: _____

Usual food intake: _____

Health and Social Service program participation: ❑ WIC ❑ Food Stamps ❑ Medicaid ❑ ILP ❑ HCP-CSHCN ❑ ATAP ❑ Healthy Families ❑ Other: _____

Objective

Prepregnancy Weight _____ Height _____ Weight gain _____ Weeks gestation _____ Due date _____

Laboratory Values: Hemoglobin: _____ Other: _____

Medications: ❑ Yes ❑ No If yes, list: _____

Drug/Nutrient Interaction: _____

Vitamin/Mineral Supplements: ❑ Yes ❑ No Type: _____

Assessment

Diet: _____

Laboratory: _____

Weight Gain: _____

Plan (developed by client and provider)

1. Client Desired Outcomes: _____
2. Education Provided: _____
3. Action Plan: _____
4. Referrals: _____
5. Follow-up Needed? ❑ Yes ❑ No Reason for Follow-up: _____
   Date of Follow-up: _____

Signature: _____ Date: _____ Phone Number: _____

Certification Form

CERTIFICATION FORM: ALASKA WIC — * High Risk — 🖫Computer Calculated

C1	C2	C3	AK	USDA	Risk Factor
			11	101🖫	PG: Underweight; Prepregnancy BMI<19.8
					BF/NBF: Current BMI<18.5
			11	103🖫	**I/C*** : ≤ 10th% BMI or ≤ 10th% wt/lgth or stature
					(HR < 5th, <10th x2)
			12	111🖫	PG: Overweight; Prepregnancy BMI ≥ 26.1
					BF:< 6mos Prepreg BMI ≥25; ≥ 6mos Current BMI ≥25
					NBF: Prepregnancy BMI ≥ 25
			12	113🖫	C ≥ 24 months to 5 yrs ≥95th% BMI or wt/stature
			13	121🖫	I/C: ≤ 10th% length/age or ht/age
			14	131🖫	**PG*** Low Maternal Weight Gain
			14	132🖫	PG: Maternal Weight Loss During Pregnancy
			14	133🖫	PG/BF/NBF: High Maternal Weight Gain
			14	134	**I/C***: Failure To Thrive
			14	135🖫	I/C: Inadequate Growth
			16	141🖫	**I***/C: < 24 mos: BW≤ 5# 8oz (**HR-I** <5#)
			16	142🖫	**I***: Prematurity Infant born ≤ 37 wks
			17	151🖫	**I***/C < 24 mos: <10th % wt for gest. age (**HR-I**)
			17	152🖫	**I***: Head Circumference < 5th % (NCHS)
			17	153🖫	I: BW ≥9# or ≥ 90% wt for gest. age
			21	201🖫	**ALL Cat***: Low Hematocrit/Low Hemoglobin
					(HR <9gms/dl, Hct<30%)
			22	211	**ALL Cat***: High Lead levels≥10µg/dl within 12mos
			31	301	PG: Hyperemesis Gravidarum
			31	302	**PG***: Gestational Diabetes
			31	303	PG: any history of gestational diabetes (GDM)
					BF/NBF: GDM= most recent pregnancy
			32	311	PG: any history of preterm delivery (≤ 37 wks)
					BF/NBF: preterm= most recent pregnancy
			32	312	PG: any history of LBW (≤ 5# 8oz)
					BF/NBF: LBW= most recent pregnancy
			33	321	PG: any hx SAB, fetal or neonatal loss <20wks/<500gm
					BF: most recent preg and w/ ≥1 infant still living
					NBF: fetal neonatal loss= most recent pregnancy
			34	331	**PG***: Current Preg at ≤ 17 y/o (**HR** ≤ 15)
					BF/NBF: Preg at ≤ 17 = most recent preg (**HR-BF**≤15)
			34	332	PG: Conception before 16 mos - current pregnancy
					BF/NBF: Concept. before 16 mos= most recent preg
			34	333	PG: Preg at < 20yr w/ ≥ 3 pregnancies- current preg
					BF/NBF: Preg at < 20yr w/ ≥ 3 preg= most recent preg
			34	334	PG: Lack of or Inadequate Prenatal Care
			34	335	**PG***: Multifetal gestation - current pregnancy
					BF*/NBF: Mult gestation= most recent preg
			34	336	**PG***: Fetal Growth Restriction (FGR)
			34	337	PG: Large for gest. age infant - any hx (BW ≥ 9 #)
					BF/NBF: Large gest. infant= most recent preg or any hx
			34	338	PG: Pregnant Woman Currently Breastfeeding
			34	339	PG: Hx of congenital birth defect - any hx
					BF/NBF: Hx congenital birth= most recent preg
			35	341	**ALL CAT***: Nutrient Deficiency Diseases
			35	342	**ALL CAT***: Gastro-Intestinal Disorders
			35	343	**ALL CAT***: Diabetes Mellitus
			35	344	**ALL CAT***: Thyroid Disorders
			35	345	**ALL CAT***: Hypertension (includes Preg induced)
			35	346	**ALL CAT***: Renal Disease (excluding UTI)
			35	347	**ALL CAT***: Cancer

C1	C2	C3	AK	USDA	Risk Factor
			35	348	**ALL CAT***: Central Nervous System Disorders
			35	349	**ALL CAT***: Genetic and Congenital Disorders
			35	350	**I***: Pyloric Stenosis
			35	351	**ALL CAT***: Inborn Errors of Metabolism
			35	352	**ALL CAT***: Infectious Diseases
			35	353	**ALL CAT***: Food Allergies
			35	354	**ALL CAT***: Celiac Disease
			35	355	All CAT: Lactose Intolerance
			35	356	**ALL CAT***: Hypoglycemia
			35	357	**ALL CAT***: Drug-Nutrient Interactions
			35	358	**PG/BF/NBF***: Eating Disorders
			35	359	**ALL CAT***: Recent Major Surgery, Trauma, Burns
			35	360	**ALL CAT***: Other Medical Conditions
			35	361	PG/BF/NBF/C: Depression
			36	371	PG/BF: Maternal Smoking
			36	372	**PG/BF/NBF***: Alcohol and Illegal Drug Use
			37	380	ALL CAT: Other Health Risks
			38	381	ALL CAT: Dental Problems
			39	362	**ALL CAT***: Dev/Sensory/Motor Disabilty Feed Prob
			40	382	**I/C***: Fetal Alcohol Syndrome (FAS)
			41	402	ALL CAT: Vegan Diets
			41	403	ALL CAT: Highly Restrictive Diets
			49	411	I: Inappropriate Infant Feeding
			49	412	I: Early Introduction of Solid Foods < 4 mos
			49	413	I: Feeding Cow's Milk < 12 Months
			49	414	I: No Dependable Source of Iron for Infants at ≥ 6
			49	415	I: Improper Dilution of Formula
			49	416	I: Feeding Other Foods Low in Essential Nutrients
			49	417	I: Lack of sanitation (prep/handling/storage)
			49	418	I: Infrequent BF:< 2mos w/ < 8fdg or ≥2 mos w/< 6 fds
			49	419	I/C: Inappropriate use of nursing bottles
			49	420	BF: Excessive Caffeine Intake (≥ 3c coffee equivalent)
			49	421	PG/BF/NBF/C: Pica
			49	422	ALL CAT: Inadequate Diet
			49	423	ALL CAT: Inappropriate/Excessive Intake of suppls
			49	424	ALL CAT: Inadequate Vit/Mineral Supplementation
			49	425	C: Inappropriate Feeding Practices for Children
			49	426	BF/NBF: Inadequate Folic Acid Intake <400 mcg/day
			90	503	PG: Preg Women Presumptive Eligibility- 60 days
			91	501	BF/NBF/I/C: Possibility of Regression
			91	502	ALL CAT: Transfer of Certification
			92	601	BF: Breastfeeding Mother of Infant at Nut'nal Risk
			93	602	**BF***: BF Complications or Potential Comp's
			93	603	**I***: BF Complications or Potential Comp's
			94	701	I: Infant < 6 Mo Old born to WIC/ELIG Mom
			95	801🖫	ALL CAT: Homelessness
			95	802🖫	ALL CAT: Migrancy
			96	902	ALL CAT: Primary Caregiver w/ Lt'd
					ability to make feeding decisions/prepare food
			96	903	ALL CAT: Foster Care
			97	703	I: Infant Born of Woman w/ Mental Retardation/
					Alcohol/Drug Abuse During Most Recent Preg
			98	702	I: Breastfeeding Infant of Woman at Nutritional Risk
			99	901	ALL CAT: Recipient of Abuse: past 6 mos

NAME_____ DOB_____ DATES OF C1_____C2_____C3_____

Revised November 2002

Dietary Assessment Tool

Alaska WIC Program
Dietary Assessment

Rev. 1/03

Name: _____ Date: _____

Please circle the foods that this person ate in the last 24 hours and write the total number of servings in the box at the bottom of each column.

Example:
Grains
4

Grains	Fruits & Vegetables	Dairy & Milk	Meats/Meat Alternates	Fats	Snack Foods
Bagel 	Apple 	Breastmilk	Beans 	Agutaq 	Cakes 
Biscuit	Banana 	Cheese 	Beef/Pork 	Butter 	Candies 
Bread 	Bok Choy 	Cottage Cheese	Clams/Mussels/ Gumboots 	Buttermilk	Chips 
Cereal 	Broccoli 	Custard 	Eggs 	Lard	Cookies 
Crackers 	Cabbage 	Ice Cream/Milk Shakes 	Fish/Shrimp/Crab 	Margarine 	Doughnuts 
Muffin 	Carrots 	Infant Formula 	Hot Dog	Mayonnaise	French Fries 
Noodle/ Pasta 	Corn 	Milk 	Moose/ Caribou 	Muktuk	Kool-Aid 
Pancakes/ Waffles 	Grapes/Berries	Grapefruit/ Orange 	Nuts 	Oil 	Soda Pop 
Pilot/Fry Bread	Green/Long Beans 	Pudding	Peanut Butter	Salad Dressing	Tang
Rice	Juice 100%	Yogurt	Poultry/Birds	Seal Oil	Tea/Coffee
Tortilla	Lettuce		Tofu	Sour Cream	
Other	Peas		Walrus/Whale/Seal	Other	Other
	Potato/Yam		Other		
	Other	Other			
Staff only 6 ☐	5 ☐	Child/Women 2 3 ☐	2 ☐	1 ☐	1 ☐
Sample Serving: ½ bagel or 1/3 cup rice	Sample Serving: 1 small piece fruit; ½ cup raw vegetables	Sample Serving: 1 cup milk or 1 oz cheese	Sample Serving: 1 oz cooked meat or 1 egg	Sample Serving: 1 tsp	Only eat occasionally